

This form must be filled out by a Vocational Rehabilitation Counselor who has received a referral from the State Fund.



TRANSPORTATION COST ENCUMBRANCE

***** Counselor is responsible for sending
a copy of this form to each vendor *****

Original

Modification

[illegible]

Mileage Calculation

Worker's residence address at the time of training

Training site address

1st, Establish the number of miles in a round trip (by the most direct route) from residence , during the time of training, to training site. _____

2nd, Multiply miles by: The number of actual training days. X _____

3rd, Multiply total miles by the current reimbursement rate: X _____

Equals Funding allotted for Plan Travel - 0301R = _____

NOTICE: Please attach a copy of this form to the Injured Worker Travel Expense Voucher form (yellow), when submitting bill(s)

Vocational Counselor:	Date	Signature	
Company	Phone No.	FAX No.	

For Dept Use Only

Claims Manager <input type="checkbox"/> Recommend <input type="checkbox"/> <i>Not</i> Recommended	Date	Phone No.	Signature
Supervisor of Industrial Insurance <input type="checkbox"/> Approved <input type="checkbox"/> Disapproved	Date	Phone No.	Signature